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Exploring Shared Services Collaboration in Wisconsin Local Public Health Agencies: A Review of the Literature

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INTRODUCTION

Why Shared Services Collaboration? And Why Now?

In 1988, the Institute of Medicine released its report, *The Future of Public Health,* which stated, "no citizen from any community, no matter how remote, should be without identifiable and realistic access to the benefits of public health protection" (p9). In the twenty-plus years since that report, the struggle to deliver necessary public health services has continued. Public health funding is generally inadequate, and providing public health services in all communities remains a challenge (Wetta-Hall, Berg-Copas, Ablah, Herman, Kang, Orr, et al, 2007). Health departments - large and small, rural and urban - also continue to find it difficult to maintain an adequate and competent workforce (Hajat, Stewart & Hayes, 2003, Mays, McHugh, Shim, Perry, Lenaway, Halverson, et al, 2006). These challenges exist throughout the country, and Wisconsin is no exception.

One potential strategy for improving services that is being explored in many states is collaboration among local agencies, more commonly known as "regionalization" in current literature. However, to avoid confusion with our state's existing Division of Public Health regions, and also recognizing that potential collaboration may not follow geographic boundaries, this report (and the complementary exploration process, survey and interviews) uses the term "shared services collaboration."

There are several forces driving the state and national discussion regarding shared services collaboration. Three of the strongest forces are *emergency preparedness, accreditation, and economics* (Koh, Elqura, Judge, & Stoto, 2008, National Association of County and City Health Officials, 2007).

Emergency Preparedness

Public health preparedness concerns and funding have acted as a catalyst for collaboration between Local Public Health Agencies (LPHAs) in many states (Koh, et al., 2008). Much of the research on regionalization and collaboration centers in this area. In the post 9/11 era, emergency preparedness has become a national priority, and has been funded accordingly by the Centers for Disease Control and Prevention (CDC). With the realization that public health emergencies would most likely cross geopolitical boundaries, and that funding LPHAs individually would spread resources too thin to be effective, most states set up a collaborative structure for public health preparedness (Grieb & Clark, 2008, Stoto, 2008, Willams & Miyahara, 2009). Consequently, communities have been encouraged to rethink the ways in which public health is structured. (Stoto, 2008).

Accreditation

Growing interest in accreditation of LPHAs is creating a push in many states to explore ways that they, especially smaller LPHAs, can work together to meet the standards. Research shows that service delivery is positively correlated with size of the population served by an LPHA (Mays et al., 2006). The size of the LPHA and population it serves is

the strongest predictor of performance related to the ten Essential Public Health Services. Because size seems to create an advantage, smaller LPHAs may benefit by pooling resources (Mays et al., 2006). Combining resources and operations may improve service delivery by small LPHAs and offer a strategy to help smaller health departments meet accreditation standards.

Economics

Research suggests that shared service collaboration may also make good economic sense. Baker and Koplan (2002) suggest that as revenues decrease, and the memories of 2001 grow more distant, the support that public health had garnered to repair its long neglected infrastructure may once again be pushed aside in favor of other priorities. If that statement held meaning in 2002, it certainly continues to be relevant today in light of the current recession. One potential solution proposed to ease the funding and infrastructure woes of public health was consolidation of LPHAs (Baker & Koplan 2002). Other researchers support the idea of collaboration based on economics. Because many public health services have a high fixed cost, a collaborative approach and sharing of resources may offer LPHAs the opportunity to improve efficiency by creating economies of scale, and avoiding duplication of efforts (Bashir, LaFronza, Fraser, Brown, & Cope, 2003, Koh et al., 2008).

Shared Services Now

It is important to bear in mind that shared services collaboration is not a new idea. Many LPHAs already participate in some form of collaborative effort. Some may contract with a neighboring health department to inspect licensed facilities or share a planner (NACCHO, 2007). All LPHAs in Wisconsin are part of public health preparedness consortia, and many collaborate or contract with other LPHAs for other services, including family planning and HIV partner counseling services (Wisconsin local health officers, personal communication, June 9, 2009).

While there are several reasons why exploring shared services makes sense, there are also potential barriers that must be addressed if collaborations are to be successful. To better understand what may enable or limit successful collaboration, a summary review of national and state issues follows.

REVIEW

The National Picture

Collaboration among LPHAs is a topic of growing interest around the country, yet there is little literature to inform policy makers of best practice related to structure and process (Koh et al., 2008, Grieb & Clark, 2008, Stoto, 2008). Much of the research that does exist is strongly focused on regionalization as it relates to public health preparedness. This includes several case studies that provide anecdotal evidence of benefits and barriers to regionalization. The National Association of County and City Health Officials (NACCHO) recently funded work to look at regionalization and collaboration from a broader perspective in Kansas and Massachusetts. To

inform that work, the *Public Health Regionalization Study National Overview* report was produced to explore the potential impact of regionalization as well as the financial and economic aspects of regionalization in several states, including Wisconsin (NACCHO, 2007).

Lessons from Emergency Preparedness in Massachusetts, Illinois and Washington DC
As previously stated, the attention towards and subsequent funding for emergency preparedness post 9/11 served as a catalyst for regionalization, or collaboration, in many states. A series of case studies were conducted to capture the experiences of and variation among select regional functions and structures. The cases explored the reasons for developing regional collaboration, factors related to governance and sustainability, their impact on preparedness, and their impact on the broader public health system.

> In Massachusetts, the Department of Public Health determined that providing funds to its 351 LPHAs would spread resources too thinly, and therefore developed a regional structure for dispersing funding and carrying out preparedness activities (Grieb & Clark, 2008). An important factor in the Massachusetts experience is that even though the state mandated collaboration, local agency autonomy and flexibility were respected within the new regional structure. The reorganization reflected local culture and the ties to home rule, and built on existing relationships (Koh et al., 2008). For example, the LPHAs in the municipalities surrounding Boston formed Massachusetts Region 4b after years of collaborating on other public health issues such as response to West Nile Virus (Grieb & Clark, 2008).
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> The Northern Illinois Public Health Coalition was established prior to 9/11, and unlike Massachusetts, it was driven by a number of relatively strong LPHAs (Stoto, 2008). In 2001, it became a 501 (c) (4) non-profit creating a strong and very formal regional structure. In contrast, in the Washington D.C. metropolitan area, no organized regional structure exists for the public health system, although it has been designated as the National Capital Region (NCR) by the Department of Homeland Security. Most of the regional activities in the NCR are based on informal relationships and are the result of voluntary self-organization by both government and non-government agencies (Stoto & Morse, 2008). In this case, the impetus for regionalizing did not seem to be a factor in successful collaboration. However, organizational structure may have some impact. In regions with a more informal structure, competition for limited resources among local agencies was a threat to collaborative efforts (Stoto, 2008).
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> Regions with more formal agreements were not immune to threats however. While regionalization solved some issues, such as limited funding for the necessary work, additional issues emerged. Generally, funding and authority resided within LPHAs, so deciding how resources were to be shared required development of policies and memoranda of understanding (Stoto, 2008). Perceived and actual loss of autonomy and authority at the local level proved difficult. Local governments seemed more willing to share resources for low volume activities (e.g. some inspection and licensing functions)

or for functions that previously did not exist at the local level (e.g. epidemiologic capacity) (Stoto, 2008).

Keys to success

Regardless of formality of the regional structure, two issues were identified in most case studies as crucial for success and sustainability of collaborations once created: leadership and trust (Stoto, 2008).

The Kansas experience

The benefits and barriers of regionalization for preparedness purposes in Kansas were explored in a separate study. In focus groups conducted with 31 Kansas local health department employees, participants indicated:

- Regionalization was absolutely necessary and resulted in improved collaboration and communication;
- Regionalizing for preparedness improved the availability of public health services;
- Regionalizing increased efficiency and timeliness (Wetta-Hall et al., 2007).

Barriers cited in the Kansas study generally related to lack of funding and changing expectations related to the preparedness program and less to regional structure or governance issues (Wetta-Hall et al., 2007). While Kansas, like other states, has seen some success with regionalization for preparedness, it is not yet certain if this success will continue with expanded regional functions. This is described in greater detail below.

NACCHO Funded Regionalization Initiatives

Kansas and Massachusetts are working to expand their success with preparedness regionalization to provide additional public health services through their regional structures.

Kansas - Kansas has 15 regions into which counties self-selected at the time that preparedness funding became available. Each region had to consist of at least three contiguous counties. A financial incentive to regionalize was built into the funding formula, and all but two counties chose to join regions. The funding formula was inversely related to population, creating a larger incentive to smaller, more rural health agencies (S. Orr, personal communication, June 2, 2009). The regionalization process was informed by an earlier pilot process in which two county groupings explored how regionalization might improve access, services and public health capacity (Williams & Miyahara, 2009). One project chose to develop a new regional organization, while the other model focused more on functions of LPHAs that could be contracted or standardized to increase capacity and efficiency. The latter model was found to be more sustainable, and so a focus on functions that can be shared rather than organizational structure of a region has been the focus of Kansas regionalization efforts that began statewide with preparedness funding and have since expanded (Williams & Miyahara, 2009).

In informal interviews, local health officials in Kansas shared some of the enabling factors, benefits and barriers to expanded regionalization (D. Rickley, personal communication, June 9, 2009).

Benefits have included:

- Increase in population base for carrying out population-based programming
- Stakeholders (county commissioners) were more accepting of cooperative regionalization than consolidation – governing bodies do not want to lose power or control when they are funding most of the services
- Sharing resources (personnel, equipment, teaching material) and avoiding duplicative efforts – not reinventing the wheel

Barriers have included:

- Siloed funding streams - a barrier to infrastructure and systems work
- Regions may be too large to be effective with too many partners and travel distances that are too long (for example, one region has 13 counties and covers over 10,000 square miles)
- Difficult to break ties to other partners not in the region

Anecdotally, it appears that a region needs to reach a population size of approximately 50,000 in order for sharing of services to be cost-effective. This size seems adequate for looking at population health trends, and is also significant when applying for federal grant money. A county of 8,000 may have a hard time making a case to receive grant dollars, while a region of 50,000 may look much more attractive to funders (Williams & Miyahara, 2009, D. Rickley, personal communication, June 9, 2009).

Massachusetts - Massachusetts formed a committee called The Working Group, to examine regionalization of LPHAs. Local public health in Massachusetts is dominated by home rule, with 351 local health departments. Every jurisdiction is responsible for providing public health services to its constituents (NACCHO, 2008). After discussions with local health officials and review of relevant data, the Working Group concluded that regionalizing public health would benefit communities across the state by making service delivery more efficient and cost-effective. A plan was recently developed to phase in an incentive-based, voluntary, regional public health system.

Three models for regionalization are provided for LPHAs in Massachusetts.

- In the *full district model*, two or more agencies would pool resources to provide comprehensive public health services.
- In the *shared services model*, agencies would not integrate all services, but would identify specific services that lend themselves to regional strategies.
- The *cafeteria model* would establish a regional agency that would provide a variety of services that towns and LPHAs would utilize on an as-needed basis. This would generally include low volume programs, or high frequency/short season programs (NACCHO, 2008).

Financial Incentives – Utah, Missouri and Connecticut

Financial incentives were part of the strategy in Kansas. They are also currently in place in a few other states and play a role in local participation in non-mandated regionalization. Funding formulas, which include local collaboration in calculating allocations to local agencies, may impact the attractiveness of regionalization efforts (NACCHO, 2007). Utah, Missouri and Connecticut all have some funding tied to delivery of services through collaboration.

Utah encourages regionalization by basing one quarter of state funds to local agencies on regional activities. The formula structure makes the incentive greatest for counties with lower relative shares of population, poverty or land area to provide collaborative services and to encourage regionalization into areas with larger populations (note, the focus is on numbers, not rates). Of Utah's 29 counties, 23 have chosen to regionalize (NACCHO, 2007).

Like Utah, Missouri also offers incentives to collaborate by basing a proportion of state funds on regionalization. The financial impact is not as great as in Utah, and as of 2006, only 3 of Missouri's 115 LPHAs had chosen to regionalize. In both Utah and Missouri, authority is shared among the LPHAs in each region (NACCHO, 2007).

Connecticut did not build incentives into its state funding formulas. It has a separate program aimed at regionalization. Separate, population-based funding is provided to support regional operations for LPHAs choosing to form a regional structure. LPHAs share the cost of public health services that are performed by the districts. The costs are allocated based on the population of each LPHA in the district, which can result in a redistribution of expenses, an increase in total public health spending, or both. Because costs are shared, LPHAs with similar per capita spending are more likely to consider forming a regional district. If per capita spending varies too much, it can result in a large spending increase for the LPHAs that entered the region with lower per capita spending (NACCHO, 2007). This is not likely to be supported politically by local governments.

In the Connecticut model, if regionalization fails to build synergies or economies of scale, then it simply results in extra spending by LPHAs as well as the state to support region administration. However, if well thought out and executed, regionalizing may allow LPHAs to carry out public health functions more efficiently and effectively, and achieve savings that they would be unable to attain on their own (NACCHO, 2007).

Of the 81 health districts in Connecticut, 20 (25%) are regionalized health districts (NACCHO, 2007). Unlike Utah and Missouri where authority is shared among the LPHAs, in Connecticut the authority lies mostly within the regional district (NACCHO, 2007).

Wisconsin

Current Collaborative Efforts

Local public health agencies in Wisconsin are not strangers to collaboration. As in several other states, all LPHAs participate in collaborative activities related to public health preparedness, as well as in other areas. Based on informal communication with local health officers, examples of current collaborations were gathered. These shared service collaborative areas include:

- WIC
- Tobacco coalitions
- Mosquito/vector control programs
- Breast-feeding task force (i.e. Chippewa Valley Breast Feeding Task Force)
- Interagency Environment Agreement-Health Specialist Coverage
- Nutrition networks (i.e. Western Wisconsin Nutrition Network)
- Children and youth with special health care needs
- Reproductive health
- Radon programs (i.e. West Central Wisconsin Radon Information Center)
- Multi-jurisdictional HIV partner services.

Several LPHAs may elect to work collaboratively on the public health service area, and in some cases, an LPHA contracts with another to provide the service. This is done more frequently with direct services. (Wisconsin local health officers, personal communication, June 9, 2009).

The amount and types of collaboration vary from LPHA to LPHA, but all Wisconsin agencies have some experience in shared service collaboration. This may be for planning purposes, provision of direct services, or both.

Financial Incentives and Barriers

Wisconsin currently allocates federal and state monies to LPHAs using a funding formula which accounts for, in some combination, agency service level, total population, target population, risk factors, and geographic factors. For some programs, like public health preparedness, a base amount is distributed to all LPHAs, with additional allocation determined using the funding formula.

The provision of base funding may discourage LPHAs from actually consolidating, since going from three separate health departments to one regional agency would mean going from three funding bases to one. Depending on the size of the base allocation, this could be a significant loss. However, it does not seem to impact collaboration between LPHAs in Wisconsin in the same way. As stated, preparedness is a base-funded program, and all LPHAs work in collaboration with others in this program area.

Factors in the funding formula may also contribute to a consolidation versus collaboration debate. The formula gives weight to land area, acknowledging that large geographic areas with low population density present a special set of challenges to health authorities. The financial boost given to small rural LPHAs with the inclusion of this factor may make it easier for such agencies to maintain independence (NACCHO, 2007). It is possible that Bernet overestimates

the impact of this factor in the NACCHO report since the amount of funding connected with geographic area is often a small percentage overall, and may be more than offset by the weight given to population in the formula.

CONCLUSIONS

The available research supports the need to look at current public health infrastructure and to explore ways to strengthen local public health systems. A need for more efficient use of resources, the growing interest in accreditation, and the general idea that all people deserve to receive certain public health services, are factors pushing public health leaders to reconsider current systems.

Despite the recognition of shared services collaboration as one potential solution to public health service improvement, little research exists in this area. The limited research available does not support a single, definitive organizational structure or process. It also does not indicate whether collaboration positively impacts health outcomes. Nonetheless, the research may serve as a starting point for discussion around the potential of building shared services collaboration efforts in Wisconsin.

For many functions, it seems that some sort of resource sharing could increase efficiency. Organizational structures that respect local autonomy are more likely to work where home rule is established (Koh et al., 2008). A focus on functions that can be shared, rather than on organizational structure may have long-term impact on sustainability (Williams & Miyahara, 2009). Local governments may be more supportive of collaboration and cooperation rather than consolidation. In addition, local governments may be more supportive of sharing of resources for low volume activities, and to build capacities that currently do not exist at the local level (Stoto, 2008).

Financial incentives are likely necessary to gain local support for collaborative activities, and must be large enough to have an impact at the local level. LPHAs must be included in the process of developing such incentives (NACCHO, 2007). States must be sensitive to a potential loss of LPHA autonomy in shared service collaborations and provide incentives to make the process more attractive (NACCHO, 2007). Conversely, local governments and agencies may benefit from reframing their view on autonomy. If they view autonomy as their right to partner with whomever they choose, they might be better positioned to withstand variable funding streams (NACCHO, 2007).

Wisconsin LPHAs have significant experience with shared service collaborations. Building on this foundation by reviewing national and state experiences and trends, current funding and infrastructure challenges, and articulating shared principles, will be an important step for public health leaders.

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